Because life is precious...

Hospice at Home
Lakeland Health Affiliate

January 25, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
131 Russell Senate Building
Washington, D.C. 20510

The Honorable Mark Warner
Co-Chair, Chronic Care Working Group
475 Russell Senate Building
Washington, D.C. 20510

Re: Response to *Bipartisan Chronic Care Working Group Policy Options Document*

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

First, let me thank you for the time and dedication you have put into this process, and for the opportunity to provide feedback. As a hospice provider who is familiar with the nuances of care for people with chronic illnesses, and knowing that you want to proceed thoughtfully, there are a few points in the Policy Options Document I would like to submit for your consideration, mainly the complications involved for patients and providers if the Medicare Advantage program becomes used as a hospice payer:

- Patients who use Medicare Advantage will be limited to using an in-network hospice. As you know, there is a wide variety of hospices, both for-profit and not-for-profit, and they can vary drastically in quality and services offered.

- It's apparent from the Policy Options document that you care greatly about improving care for patients and wish to move toward a team approach. This is exciting, because it's what hospice is all about: a team of experts caring for a patient from all perspectives - physically, emotionally and spiritually. Medicare Advantage plans, however, tend to dilute the strength of hospice care, offering some but not all of these services. There is a focus on physical care, but less on other important aspects - for example, psychosocial and bereavement services. We know from over 35 years of experience in this field that these services are crucial to the wellbeing of the patient during this intense and meaningful time.

- Medicare Advantage plans can inadvertently work against the patient's best interest by overruling the Hospice Medical Director's plan of care regarding what is related to the prognosis. Doing this in an office from afar, without the benefit of eyes and ears focused on the patient in their environment, cannot possibly lead to the best care for people with chronic illnesses.

- Speaking from the perspective of a non-profit hospice, who tries to put as much of our resources as possible into patient care and community services, the burden of billing and negotiating with all the different Medicare Advantage plans would force us to spend our limited resources on administrative costs. Instead of being able to provide better care and more services, we would have to hire experts to bill. We would have to spend resources training all of our social workers and admission staff on the nuances of the different plans so they can explain to patients and families what is covered and what is not under their particular plan.

  Additionally, as you can imagine, end-of-life can be an emotional, confusing and stressful time for patients and their families. They are already having to make decisions they never wanted to make and being overwhelmed with choices and paperwork. The addition of Medicare Advantage program confusion does not seem worth it, since it will not necessarily be providing better care, but rather more puzzle pieces to decide on.

- Finally, though the goal of this suggested policy change is to provide patients with more choice and options in their care, I believe this will, in the long run, actually reduce patient choice. Again, as a non-profit hospice already struggling with the administrative costs of increased regulation, a new billing model, and potentially facing lower reimbursement, the additional administrative maintenance it would take to deal with Medicare Advantage plans could seriously threaten our financial stability. For-profit hospices, who don't necessarily put their resources back into patient care, are better equipped to absorb these costs. Over the long term, patients could be limited in their choices not only by what's available in-network, but by having fewer hospices to choose from based on who can survive with the increased operating costs.

Thank you for the opportunity to submit remarks. I look forward to ongoing discussion about how to provide people with chronic illnesses and near the end of life with the best possible care – the goal shared by all of us.

With Warm Regards,

Melinda Graham
Chief Executive Officer, Hospice at Home